STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING _____ B. WING _____	C 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	**7935 CALUMET AVE MUNSTER, IN 46321**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00195776 and IN00196941. Complaint IN00195776- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00196941- Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 11 & 12, 2016 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census bed type: SNF: 17 SNF/NF: 181 Total: 198 Census payor type: Medicare: 35 Medicaid: 103 Other: 60 Total: 198 Sample: 10 Munster Med Inn was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00195776 and IN00196941. QR was completed by 99993 on 04/13/16.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE